

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2012	
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00103084, IN00103896, IN00104044 and IN00104378.</p> <p>Complaint IN00103084: Substantiated, no deficiencies related to the allegation are cited</p> <p>Complaint IN00103896: Unsubstantiated: due to lack of evidence</p> <p>Complaint IN00104044: Substantiated, no deficiencies related to the allegation are cited</p> <p>Complaint IN00104378: Unsubstantiated: due to lack of evidence</p> <p>Survey dates: February 24, 27 and 28, 2012</p> <p>Facility number: 000131 Provider number: 155228 AIM number: 100274910</p> <p>Survey team: Vanda Phelps, RN</p> <p>Census bed type: SNF/NF: 108 Total: 108</p> <p>Census payor type: Medicare: 16 Medicaid: 75 Other: 17 Total: 108</p> <p>Sample: 7</p> <p>North Capitol Nursing and Rehabilitation Center</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2012
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of complaint numbers IN00103084, IN00103896, IN00104044 and IN00104378. Quality review completed 2/29/12 Cathy Emswiller RN	F 000			